| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155291 | A. BUILDING 00<br>B. WING | 11/21/2011 |

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| EAGLE VALLEY MEADOWS | 3017 VALLEY FARMS RD<br>INDIANAPOLIS, IN46214 |

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| F0000 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00099640 and IN00099871.<br><br>Complaint IN00099640: Unsubstantiated due to lack of evidence.<br><br>Complaint IN00099871: Unsubstantiated due to lack of evidence.<br><br>Survey dates: November 14, 15, 16, 17, 18, and 21, 2011<br><br>Facility number: 000188<br>Provider number: 155291<br>AIM number: 100266310<br><br>Survey team:<br>Janet Stanton, R.N.--Team Coordinator<br>Rita Mullen, R.N.<br>Heather Lay, R.N. (11/14, 16, 17, 18, 21)<br><br>Census bed type:<br>SNF--7<br>SNF/NF--92<br>Total--99<br><br>Census payor type:<br>Medicare--11<br>Medicaid--69<br>Other--19 | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Total--99<br><br>Sample: 20<br>Supplemental sample: 3<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review 11/30/11 by Suzanne Williams, RN | | | |
| F0253<br>SS=D | The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br>Based on observation, record review and interview, the facility failed to provide a clean resident bathroom. The deficient practice impacted 2 of 3 residents reviewed for toileting in a supplemental sample of 3. [Resident #93 and Resident #97]<br><br>Findings include:<br><br>Environmental tour was initiated on 11/16/2011 at 8:45 A.M. with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor.<br><br>At 9:15 A.M. the bathroom of Resident #93 and Resident #97 had yellow soiled towels located around the base of the toilet.<br><br>In an interview at 9:15 A.M., the | F0253 | **F 253 Housekeeping and Maintenance Services** It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The towels were removed from the floor of the bathroom for resident # 93 and #97. A care plan was created for resident #93 and #97 that addresses the residents' requests for towels to be placed on the floor during toileting. The housekeeping and nursing staff were educated on infection control and not placing towels on the floor by the Staff Development Coordinator on 12/08/11. The C.N.A. assignment sheets for resident #93 and #97 were updated to | 12/16/2011 |

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| | Housekeeping/Laundry Supervisor indicated both residents miss the toilet and the towels are used to soak up the urine. He indicated the C.N.A.s are to change the towels; however, not certain of how often the towels are to be changed.<br><br>In an interview at 9:35 A.M., the Executive Director indicated the use of towels around the base of the toilet was addressed last week, which resulted from a tour of the facility by a Quality Assurance committee member. She indicated staff were instructed not to leave soiled towels around the base of toilet or on the toilet.<br><br>The C.N.A. assignment sheet, dated 11/16/2011, was received on 11/16/2011 at 11:25 A.M. from the Executive Director. The sheet included, but was not limited to, Resident #97 "... Mobility/Transfers: Walks with cane, wheelchair as needed... Special Needs: Extra large toilet riser in the bathroom for comfort. No towels around toilet base or on toilet... " Resident #93, "... Mobility/Transfers: A 1 [Assist of one], wheelchair, may use walker... Special Needs: No towels around toilet seat or on floor of bathroom."<br><br>On 11/16/2011 at 1:20 P.M., the Executive Director provided a document, | | reflect the plan of care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents who use the toilet have the potential to be affected by this practice. · Nursing and Housekeeping staff were educated on infection control 12/8/11 by Staff Development Coordinator. See attachment 1. · IDT team to review the care plans for residents who use the toilet to ensure accuracy by 12/16/11. · C.N.A. assignment sheets will be updated to reflect the plan of care for toileting by 12/16/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Each resident will be assessed for a toileting program upon admission, annually and with significant change. · The MDS Coordinator/designee will set up a toileting program for those residents who are identified through the assessment process. · A toileting care plan will be implemented for residents requiring a toileting program. · The C.N.A assignment sheets will reflect residents on a toileting program. · All staff to be educated on infection control practices quarterly. · Department managers will conduct daily rounds to monitor bathroom | |

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| | no title, with information from the Quality Assurance committee tour member regarding the soiled towels in Resident #93 and Resident #97's bathroom. The document included, but was not limited to, "November 7 and 8, 2011: Environmental Tour... [Resident #93 and Resident #97] Room has toilet riser with towels over the seat, towels are soiled... Positive Comments: Items mentioned were addressed quickly..."<br><br>3.1-19(f) | | cleanliness, including the removal of soiled towels. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The Executive Director and or DNS will review the Daily rounds check list daily to ensure the bathrooms are clean and no towels are on the floor. · The Bladder Program CQI tool will be completed by DNS/designee weekly for four weeks, monthly for three months and quarterly for two quarters unless threshold not met. See attachment 2. · The Care Plan Updating CQI tool will be completed by the MDS Coordinator weekly for four weeks, monthly times three months and quarterly thereafter. See attachment 3. · Data collected will be submitted to the CQI committee for review. If threshold of 90% is not achieved, an action plan will be developed. **Compliance date: 12/16/11** | |

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| F0279 SS=D | A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br>Based on observation, interview, and record review, the facility failed to update the resident's toileting Care Plan. The deficient practice impacted 2 of 3 residents reviewed for a toileting Care Plan in the supplemental sample of 3. [Resident #93 and Resident #97]<br><br>Findings include:<br><br>Environmental tour was initiated on 11/16/2011 at 8:45 A.M. with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor.<br><br>At 9:15 A.M. the bathroom of Resident #93 and Resident #97 had yellow soiled | F0279 | **F 279 Develop Comprehensive Care Plans** A facility must use the results of assessments to develop, review, and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any services that would otherwise be required under 483.25 but are not | 12/16/2011 |

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| | towels located around the base of the toilet.<br><br>In an interview at 9:15 A.M., the Housekeeping/Laundry Supervisor indicated both residents miss the toilet and the towels are used to soak up the urine. He indicated the C.N.A.s are to change the towels; however, not certain of how often the towels are to be changed.<br><br>In an interview at 9:35 A.M., the Executive Director indicated the use of towels around the base of the toilet was addressed last week which resulted from a tour of the facility by a Quality Assurance committee member. She indicated staff were instructed not to leave soiled towels around the base of toilet or on the toilet.<br><br>On 11/16/2011 at 2:00 P.M., Resident #93's record was reviewed. No toileting care plan was noted.<br><br>On 11/16/2011 at 2:15 P.M., Resident #97's record was reviewed. No toileting care plan was noted.<br><br>The C.N.A. assignment sheet, dated 11/16/2011, was received on 11/16/2011 at 11:25 A.M. from the Executive Director. The sheet included, but was not limited to, Resident #97, "... | | provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10 (b) (4).<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A care plan was created for resident #93 and #97 that addresses the residents' requests for towels to be placed on the floor during toileting 11/21/11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents who use the toilet have the potential to be affected by this practice. · IDT team to review the care plans for residents who use the toilet to ensure accuracy by 12/16/11.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Each resident will be assessed for a toileting program upon admission, annually and with significant change · The MDS Coordinator/designee will set up a toileting program for those residents who are identified through the assessment process. · A toileting care plan will be implemented for residents requiring a toileting program. · Toileting care plans will be | |

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| | Mobility/Transfers: Walks with cane, wheelchair as needed... Special Needs: Extra large toilet riser in the bathroom for comfort. No towels around toilet base or on toilet..." Resident #93, "... Mobility/Transfers: A 1 [Assist of one], wheelchair, may use walker... Special Needs: No towels around toilet seat or on floor of bathroom."<br><br>On 11/16/2011 at 1:20 P.M., the Executive Director provided a document, no title, with information from the Quality Assurance committee tour member regarding the soiled towels in Resident #93 and Resident #97's bathroom. The document included, but was not limited to, "November 7 and 8, 2011: Environmental Tour... [Resident #93 and Resident #97] Room has toilet riser with towels over the seat, towels are soiled... Positive Comments: Items mentioned were addressed quickly..."<br><br>On 11/21/2011 at 3:20 P.M., the Executive Director provided a toileting Care Plan for Resident #93 and Resident #97.<br><br>Resident #97's Care Plan included, but was not limited to, "Problem start date: 11/16/2011... Resident wishes to have towels on toilet seat and around the base. Resident will request towels prior to | | reviewed quarterly by the IDT team for accuracy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The Bladder Program CQI tool will be completed by DNS/designee weekly for four weeks, monthly for three months and quarterly for two quarters unless threshold not met. See attachment 2. · The Bowel Elimination CQI tool will be completed by DNS/designee weekly for four weeks, monthly for three months and quarterly for two quarters unless threshold not met. See attachment 4. · The Care Plan Updating CQI tool will be completed by MDS Coordinator weekly for four weeks, monthly for three months, and quarterly thereafter. See attachment 3. · The Care Plan Review CQI tool will be completed by MDS Coordinator weekly for four weeks, monthly for three months and quarterly thereafter. See attachment 5. · Data collected will be submitted to the CQI committee for review. If threshold of 90% is not achieved, an action plan will be developed. **Compliance date: 12/16/11** | |

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| | toileting. Resident has history of soiling toilet with stool and urine on and outside the toilet... Goal: Resident encouraged not to use towels on or around toilet during toileting... Approach: Explain risks of using towels on or around toilet to resident if towels requested..."<br><br>Resident #93's Care Plan included, but was not limited to, "Problem start date: 11/21/2011... Resident wishes to have towels on toilet seat and around the base. Resident has history of soiling toilet with stool and urine on the outside of the toilet... Goal: Resident will be comfortable on the toilet seat. Resident will be encouraged not to use towels on or around toilet seat during toileting... Approach: Explain the risks of using towels on or around toilet to resident if requested..."<br><br>3.1-35(a) | | | |
| F0282 SS=D | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on record review, observation and interview, the facility failed to follow the Plan of Care for a non-slip surface on the wheelchair cushion of a resident with a | F0282 | **F 282 Services by Qualified Persons per Care plan** The services provided or arranged by the facility must be provided by qualified persons in accordance | 12/16/2011 |

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| | history of falls. This impacted 1 of 9 residents reviewed for falls in a sample of 20. (Resident #90)<br><br>Findings include:<br><br>The clinical record of Resident #90 was reviewed on 11/15/11 at 10:00 A.M.<br><br>Diagnoses for Resident #90 included, but were not limited to, Alzheimer's disease, depression and high blood pressure.<br><br>A Significant Change Minimum Data Set Assessment, dated 9/13/11, indicated Resident #90 had long and short memory problems and impaired decision making skills.<br><br>An Interdisciplinary Team (IDT) note, dated 11/3/11 at 10:30 A.M., indicated "IDT review of fall: Res (resident) had a fall on 11/2/11 at 5:15 pm (sic). Prior to fall res was sitting in w/c (wheelchair) in room. CNA stated she started to back res w/c out of room and the res slid out of it. Res does lean forward in w/c. Res was fully dressed. No injuries noted. Room was cluttered at time of fall. IDT agree (sic) to add dycem (a non-slip surface) to w/c, res is currently on therapy caseload....."<br><br>A Fall Even, dated 11/2/11, indicated | | with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The dycem was replaced in the wheelchair of resident # 90. The care plan for resident #90 reflects the dycem in the wheelchair. The C.N.A. assignment sheet communicates need for dycem in the wheelchair. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents who have dycem in the wheelchair have the potential to be affected by this deficient practice. · IDT reviewed all residents with dycem to ensure that equipment was in place 12/9/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Checklist/Rounds will be completed daily for each resident by Department managers to ensure adaptive equipment is in place. See attachment 6. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The ED/DNS will collect the Checklist/Rounds tool daily to ensure completion. · The Fall | |

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| | Resident #90 had a fall from her wheelchair. There was clutter in the room, therapy was notified and the wheelchair needs a dizem (sic).<br><br>A Care Plan for falls, dated 9/20/11 and up-dated 11/1/11 and 11/3/11, indicated Resident #90 had a risk for falls related to having impaired mobility,, having a history of falling, impaired vision, use of a wheelchair, being dependent on staff for transfers, history of non-compliance and poor safety awareness. Approaches included, but were not limited to, Dycem above and below cushion in w/c, 2 person assist with transfers and non-skid foot wear.<br><br>During an observation of Resident #90, on 11/16/11 at 11:25 A.M., she was resting in bed. The wheelchair was setting beside the bed. There was a Roho cushion in the wheelchair but there was no dycem as indicated in the Care Plan.<br><br>During an interview with the Director of Nursing, on 11/16/11 at 11:30 A.M., she indicated there should be dycem above and below the wheelchair cushion.<br><br>3.1-35(g)(2) | | Management CQI tool will be completed by the DNS/designee weekly for four weeks, monthly for three months and quarterly thereafter. See attachment 7. · Data collected will be submitted to the CQI committee for review. If threshold of 90% is not achieved, an action plan will be developed. **Compliance date: 12/16/11** | |

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| F0323 SS=E | The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>A. Based on interview and record review, the facility failed to provide adequate supervision to a resident with a history of elopement from the facility. The deficient practice impacted 1 of 1 resident reviewed with a history of elopement from a sample of 20 residents reviewed. [Resident #6]<br><br>B. Based on observation and interview, the facility failed to secure a meat fork on the locked dementia unit. The deficient practice had the potential to impact 19 of 19 residents on the locked dementia unit.<br><br>C. Based on record review, observation and interview, the facility failed to consistently implement the Plan of Care for a non-slip surface on the wheelchair cushion of a Resident with a history of falls. This impacted 1 of 9 residents reviewed for falls in a sample of 20. (Resident #90)<br><br>Findings include:<br><br>A.1. On 11/14/2011 at 9:30 A.M., Indiana State Department of Health [ISDH] "Intake Information" was reviewed regarding an incident with Resident #6. The document included, but | F0323 | **F 323 Free of Accident Hazards/Supervision/Devices**<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>On 10/11/11 an order was received to place resident #6 on one to one observation twenty-four hours per day.<br><br>The meat fork was removed from the dementia unit on 11/16/11.<br><br>The dycem was replaced on the w/c for resident # 90 on 11/16/11.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**<br><br>· All residents who are at risk for | 12/16/2011 |

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| | was not limited to, "Entity Reported Incident... Date of Alleged Event: 10/11/2011... [Resident #6] noted to be sitting outside in patio... Continuous one to one supervision..."<br><br>On 11/14/2011 at 11:10 A.M., tour was initiated with the Minimum Data Set coordinator [M.D.S.]. The M.D.S. coordinator indicated Resident #6 had a history of behaviors requiring 1 on 1 supervision 24 hours per day and was not interviewable.<br><br>Resident #6's record was reviewed on 11/17/2011 at 1:25 P.M. Diagnoses included, but were not limited to, progressive dementia, psychotic symptoms, depressed mood, and Alzheimer's disease.<br><br>Resident #6's elopement Care Plan included, but was not limited to, "Problem start date: 6/01/2011, Resident at risk for elopement due to: wandering to doors and holding down handle till door opens... Approach Start Date: 6/1/2011: Electronic monitoring bracelet placed on wheelchair or ankle... Approach Start Date: 7/11/2011: 1:1 supervision with resident..."<br><br>A Nurse's Progress Note dated 5/31/2011 at 7:25 P.M. included, but was not limited | | elopement have the potential to be affected by this deficient practice.<br>· All residents are assessed for elopement risk upon admission, annually, and with significant change.<br>· IDT to review the elopement risk and determine if security bracelets are needed. Security bracelets will be placed on those residents identified by IDT to be necessary.<br>· Residents at risk will be added to the elopement book. Residents at risk will be noted on the C.N.A. Assignment sheets.<br>· A care plan will be implemented for all residents who are at risk for elopement.<br>· Licensed professional staff will check for placement and function of the security bracelets every shift.<br>· All residents on the dementia unit have the potential to be affected by this deficient practice.<br>· All staff educated on environmental safety by 12/16/11 by Staff Development Coordinator. See attachment 8.<br>· All residents with dycem have the potential to be affected.<br>· IDT reviewed all residents with dycem to ensure that equipment was in place 12/9/11.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>· All exit doors have been secured with wanderguard alarms that will notify staff of residents attempting to exit 12/2/11.<br>· The Department head team was educated on the Checklist/Rounds tool on 12/09/11 by the Executive Director. | |

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| | 155291 | A. BUILDING 00<br>B. WING | 11/21/2011 |

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| | to, "Resident went out B-Hall door... noted to be sitting in wheelchair outside... no apparent injury..."<br><br>A Nurse's Progress Note dated 6/12/2011 at 5:34 P.M. included, but was not limited to, "Resident exited through front door this a.m.... watch every 15 minutes to make sure remains in building..."<br><br>A Nurse's Progress Note dated 7/4/2011 at 2:40 P.M. included, but was not limited to, "Staff noted that resident had opened therapy door and exited... 15 minute checks started..."<br><br>An Interdisciplinary Team [IDT] Progress Note dated 10/10/2011 at 9:49 A.M. included, but was not limited to, "Resident had behaviors on 10/8/11 and 10/9/11... hitting staff, yelling at staff, grabbing peers wheelchairs, punching wall, tearful, and exit seeking... IDT in agreement to continue one on one [supervision]..."<br><br>A Nurse's Progress Note dated 10/10/2011 at 9:49 P.M. included, "Order obtained for wonderguard (sic) due to elopement risks."<br><br>A Nurse's Progress Note dated 10/11/2011 at 4:02 A.M. included, but was not limited to, "Resident exited the building, not | | See attachment 9.<br>· The Checklist/Rounds will be completed daily for each resident by Department Managers to ensure adaptive equipment is in place and hazardous materials are removed. See attachment 6.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>· The Missing Resident/Elopement CQI tool to be completed by the DNS/designee weekly for four weeks, monthly for three months, and quarterly for two quarters unless threshold not met. See attachment 10.<br>· The ED/DNS will collect the Checklist/Rounds tool daily to ensure completion.<br>· The Fall Management CQI tool will be completed by the DNS/designee weekly for four weeks, monthly for three months and quarterly thereafter. See attachment 7.<br>· Data collected will be submitted to the CQI committee for review. If threshold of 90% is not achieved, an action plan will be developed.<br><br>**Compliance date: 12/16/11** | |

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| | accompanied by staff. Staff was doing 15 minute checks when it was noticed that resident was not in visual sight. Staff began looking for the resident down the halls, in every room. Staff noted resident outside in back propelling self in wheelchair holding on to a side rail that was along the walkway. Alarm [wanderguard] did not sound... Resident safe inside with staff doing one on one..."<br><br>A physician's order dated 10/8/2011 included, but was not limited to, "Resident on 1:1 [one to one supervision] while awake and 15 minute checks when asleep..."<br><br>A physician's order dated 10/11/2011 included, but was not limited to, "Discontinue previous 1:1 order. Resident on 1:1 until evaluated by psych..."<br><br>Resident #6's Minimum Data Set [M.D.S.] assessment, dated 10/28/2011, included, but was not limited to, "Brief Interview for Mental Status [BIMS] 3 [severe impairment to mental status]... Locomotion off unit: limited assist, one person physical assist..."<br><br>A document titled "Safety Check List-Hourly" was received from the Director of Nursing Services. The | | | |

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| | document included hourly charting on Resident #6 for the dates of 10/8/11 at 7:00 A.M. through 10/11/11 at 6:00 A.M.<br><br>In an interview on 11/21/2011 at 3:00 P.M. with the Director of Nursing Services, she indicated charting regarding nursing's "every 15 minute" checks on Resident #6 were not available. She indicated there was no policy regarding 15 minute charting; however, she expected nursing staff to document 15 minute checks on correct sheets.<br><br>In an interview on 11/21/2001 at 4:50 P.M., the Executive Director indicated after the elopement on 10/11/2011, a work request was made to install wanderguard alarms on all facility doors because the only door with a wanderguard alarm was the front entrance door. She indicated Resident #6 was fast and could get out of the facility quick.<br><br>B.1. In an interview during the initial orientation tour on 11/14/2011 at 11:08 A.M., L.P.N. #2 indicated 18 of the 19 residents residing on the secure/locked Alzheimer's unit were able to walk by themselves throughout the unit. One resident was mobile by using a wheelchair, and was able to propel herself around unit. | | | |

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| | On 11/16/2011 at 8:45 A.M., environmental tour was initiated with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor.<br><br>At 9:15 A.M., a meat fork was observed in the locked dementia unit kitchen drawer. The kitchen drawer was not locked and did not have a lock on it.<br><br>On 11/16/2011 at 10:15 A.M., C.N.A. #3 indicated she did not know the meat fork was in the kitchen drawer and removed it.<br>C.1. The clinical record of Resident #90 was reviewed on 11/15/11 at 10:00 A.M.<br><br>Diagnoses for Resident #90 included, but were not limited to, Alzheimer's disease, depression and high blood pressure.<br><br>A Significant Change Minimum Data Set Assessment, dated 9/13/11, indicated Resident #90 had long and short memory problems and impaired decision making skills.<br><br>An Interdisciplinary Team (IDT) note, dated 11/3/11 at 10:30 A.M., indicated "IDT review of fall: Res (resident) had a fall on 11/2/11 at 5:15 pm (sic). Prior to fall res was sitting in w/c (wheelchair) in room. CNA stated she started to back res w/c out of room and the res slid out of it. Res does lean forward in w/c. Res was | | | |

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| | fully dressed. No injuries noted. Room was cluttered at time of fall. IDT agree (sic) to add dycem (a non-slip surface) to w/c, res is currently on therapy caseload....."<br><br>A Fall Even, dated 11/2/11, indicated Resident #90 had a fall from her wheelchair. There was clutter in the room, therapy was notified and the wheelchair needs a dizem (sic).<br><br>A Care Plan for falls, dated 9/20/11 and up-dated 11/1/11 and 11/3/11, indicated Resident #90 had a risk for falls related to having impaired mobility,, having a history of falling, impaired vision, use of a wheelchair, being dependent on staff for transfers, history of non-compliance and poor safety awareness. Approaches included, but were not limited to, Dycem above and below cushion in w/c, 2 person assist with transfers and non-skid foot wear.<br><br>During an observation of Resident #90, on 11/16/11 at 11:25 A.M., she was resting in bed. The wheelchair was setting beside the bed. There was a Roho cushion in the wheelchair but there was no dycem as indicated in the Care Plan.<br><br>During an interview with the Director of Nursing, on 11/16/11 at 11:30 A.M., she | | | |

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| | indicated there should be dycem above and below on the wheelchair cushion and that the wheelchairs were washed the night before and the dycem must not have been put back in the wheelchair.<br><br>3.1-45(a)(1)<br>3.1-45(a)(2) | | | |
| F0425<br>SS=D | The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br>Based on observation, record review and interview, the facility failed to appropriately dispose of an expired medication. The deficient practice impacted 1 of 1 resident reviewed with an expired medication located in the facility's medication refrigerator in a supplemental sample of 3. [Resident #84] | F0425 | **F425 Pharmaceutical SVC-Accurate Procedures**<br>The facility must provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in 483.75 (h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical | 12/16/2011 |

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| | Findings include:<br><br>Tour of the medication room was initiated on 11/17/2011 at 9:30 A.M. with the Unit Manager. At 9:35 A.M., Resident #84's medication, Amlodipine 5 milligrams per 5 milliliters liquid, had an expiration date of 7/21/2011. The bottle was observed to have been opened with a small amount of liquid left in the bottle.<br><br>On 11/21/11 at 11:00 A.M., Resident #84's record was reviewed. Diagnoses included, but were not limited to, dysphagia, respiratory failure, anemia, expressive aphasia, history or stroke, and dementia with psychosis.<br><br>The resident's medication administration record dated 10/1/11 through 10/21/11 and medication administration record dated 11/1/11 through 11/30/11 indicated the resident received Amlodipine 5 milligrams per 5 milliliter per gastronomy tube once daily at 6 A.M.<br><br>In an interview on 11/17/2011 at 9:35 A.M., the Unit Manager indicated she expected medications with expiration dates to be discarded.<br><br>A document titled, "Expiration Dating" with a revised date of 7/2011 from the Pharmacy Policy and Procedure Manual, | | services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>The expired medication for resident #84 was disposed of according to facility policy on 11/17/11.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**<br><br>· All residents have the potential to be affected by this deficient practice.<br>· All medication carts were audited by nurse managers to ensure no expired meds were present on 11/17/11.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>All licensed staff were educated on handling expired meds by the Staff | |

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| | was received from the Executive Director on 11/17/2011 at 10:50 A.M. The document included, but was not limited to, "Purpose: To ensure integrity of medications... Procedure: Medication must be checked by the facility regularly for expiration dates and deterioration... Expired medications will be removed form use and destroyed..."<br><br>In an interview on 11/21/2011 at 12:05 P.M. with the Assistant Director of Nursing [ADoN], she indicated the facility's contract pharmacy checks all medication on a monthly basis and not certain how this medication was missed since July 2011. She indicated a new bottle of medication was delivered on 11/17/2011 for Resident #84.<br><br>3.1-25(o) | | Development Coordinator by 12/16/11. See attachment 12.<br><br>Pharmacy Services to audit medication carts and refrigerator every month. Report reviewed by DNS.<br><br>Licensed Nursing Staff to check refrigerator every night for expired medications. See attachment 14.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>· The Medication Storage Review CQI tool will be completed by DNS/designee weekly for four weeks, monthly times three months and quarterly for two quarters unless threshold not met. See attachment 13.<br>· Data collected will be submitted to the CQI committee for review. If threshold of 90% is not achieved, an action plan will be developed.<br><br>**Compliance date: 12/16/11** | |